

Patient Name: _____

Date of Birth: _____ Gender: M F

Nickname: _____

Patient SSN: _____

Address: _____

Marital Status: Single Married

City: _____ State: _____ Zip: _____

Widowed Divorced Decline to Specify

Phone: _____ Texting is OK

Employer: _____

Email: _____

Occupation: _____

Communication Preference: _____

Phone Text Email

Race: Amer. Indian Asian Black

Decline to Specify European White

Other: _____

Ethnicity: Hispanic Not Hispanic

Parent/Guardian Name (if applicable): _____ Parent/Guardian DOB: _____

Emergency Contact: _____ Emergency Phone: _____

For new patients, how did you hear about us?

Drive by Google Our website Vision Plan Facebook Other: _____

Referred by: _____

Questions about your visit today:

Are you currently wearing glasses or contacts today? Glasses Contacts Neither

Glasses / Lasik

Are you interested in new glasses if helpful? Yes No

Are you interested in information about Lasik? Yes No

Contacts

A contact lens **examination fee** is required when first prescribing or updating a current contact lens prescription. This fee covers the additional time and any follow-up visits to fit the contacts.

Our contact lens fittings start at \$60 and depend on the difficulty of the fit. Please refer to front desk staff for any pricing questions.

Are you interested in wearing/updating contacts? Yes No

Medicare and Other Medical Insurances

By signing, I understand that Insight Eyecare may bill my medical insurance if my exam is not a routine vision exam. I understand that Insight Eyecare is contracted to follow my insurance’s billing rules. That may include charging a copay for each visit and that the entire balance of the visit may get applied towards my deductible (which the patient is responsible for) if my insurance plan deems proper. I understand that any service provided not covered by my medical insurance may be my responsibility.

HIPAA

By signing, I agree to and understand that this clinic complies with all requirements of HIPAA, my rights to my records and privacy. I understand that there are full copies of the HIPAA statement available at the front desk and waiting room.

I agree to and understand the policy summaries. I understand that full length copies are available and are posted.

If you would like to authorize us to share your records with anyone such as family or a guardian, list their names below. Without your authorization, we cannot disclose patient information to anyone.

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

By signing below, I confirm that these records are full and accurate to the best of my knowledge.

Signed Patient (or Parent/Guardian): _____ Date: _____

Prayer Request (optional): _____
 Verbal prayer in exam Silent prayer